APPLICATION FOR A LICENSE TO PRACTICE DENTISTRY OR DENTAL HYGIENE

State Form 42127 (R6 / 12-04)
Approved by State Board of Accounts, 2004

Health Professions Bureau
402 W. Washington St., Rm. W066
Indianapolis, IN 46204
Telephone Number (317) 234-2057

* Your Social Social Security number is being requested by this state agency in accordance with I. C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

FOR AGENCY USE ONLY		
Date reviewed *(month, day, year)*	Decision	Initials

OFFICE USE ONLY	
License / Exam fee	Permit fee
Date fee paid *(month, day, year)*	Date fee paid *(month, day, year)*
Receipt number	Receipt number
License number	Permit number
License issuance date (*month, day, year*)	Permit issuance date *(month, day, year)*

Applicant
Attach two (2) passport type quality photographs of yourself taken within the last eight weeks. Please sign each photo at the bottom. Negatives and Polaroids are not acceptable.

APPLICANT INFORMATION	
Name of applicant *(last, first, middle, maiden)*	* Social Security number
Address *(number and street or Rural Route number)*	
City, state, ZIP code	

Telephone number *(daytime)*	Date of birth *(month, day, year)*	Place of birth	E-Mail Address

TYPE OF LICENSE

Applying for licensure by:
☐ Endorsement ☐ Examination

Applying as a:
☐ Dentist ☐ Dental Hygienist

Are you applying for an Intern Permit?
☐ Yes ☐ No

DEGREE GRANTED BY		
Name of school	Location of school	Date of graduation *(month, day, year)*

DENTAL / DENTAL HYGIENE PROFESSIONAL EDUCATION		
NAME OF SCHOOL	LOCATION OF SCHOOL	DATES ATTENDED

PRE-DENTAL / DENTAL HYGIENE EDUCATION		
NAME OF SCHOOL	LOCATION OF SCHOOL	DATES ATTENDED

List all places of employment since graduation from Dental / Dental Hygiene School, including self-employment.			
NAME AND ADDRESS OF EMPLOYER	**RESPONSIBILITIES**	**HRS / WK**	**DATES**

EXAMINATION RECORD			
National Board Exam ☐ Yes ☐ No	If Yes, how many times?	Date of most recent test *(month, year)*	Where taken *(state or country)*
State Board Exam ☐ Yes ☐ No	If Yes, how many times?	Date of most recent test *(month, year)*	Where taken *(state or country)*
Regional Exam ☐ Yes ☐ No	If Yes, which regional, how many times?	Date of most recent test *(month, year)*	Where taken *(state or country)*
Do you hold, or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation? ☐ Yes ☐ No			

List all states, including Indiana, in which you have been licensed to practice any regulated health occupation.				
TYPE OF LICENSE	**STATE**	**NUMBER**	**DATE ISSUED**	**CURRENT STATUS**

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details. Describe the event including location, date and disposition. If malpractice, provide name of plantiff. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice dentistry/dental hygiene or any regulated health occupation in any state *(including Indiana)* or country? ☐ Yes ☐ No
3. Are you now, or have you ever been treated for a drug abuse or alcohol problem? ☐ Yes ☐ No
4. Have you ever been charged with drug addiction? ☐ Yes ☐ No
5. Have you ever been convicted of, pled guilty or *nolo contendre* to:
   A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   B. Any offense, misdemeanor or felony in any state? *(Except for minor violations of traffic laws resulting in fines)* ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restriction, probation or other type of discipline or limitations? ☐ Yes ☐ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant? ☐ Yes ☐ No
8. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

VERIFICATION OF EMPLOYMENT OR RESIDENCY FOR A DENTAL OR DENTAL HYGIENE INTERN PERMIT

INSTRUCTIONS: *Return completed form to:* **Health Professions Bureau**
402 W. Washington St., Rm. W066
Indianapolis, IN 46204

PRACTICE MAY NOT BEGIN UNTIL THE PERMIT IS ISSUED BY THE BOARD.
PERMITS ARE VALID FOR A PERIOD OF ONE YEAR.

* Required pursuant to I. C. 4-1-8-1

THIS SECTION TO BE COMPLETED BY THE APPLICANT			
Name of applicant *(last, first, middle, maiden)*		* Social Security number	
Address *(number and street or Rural Route)*	City	State	ZIP code

I hereby authorize _____ , to furnish the Health Professions Bureau with the information below.

Signature of applicant	Date *(month, day, year)*

THIS SECTION TO BE COMPLETED BY THE SUPERVISING DENTIST		
Name of employer	Title	
Name of department *(if any)*		
Address of facility *(number, street / Rural Route, city, state, ZIP code)*		Telephone number ( )
Date of employment / Residency begins *(month, day, year)*	Date of employment / Residency ends *(month, day, year)*	Position to be held by applicant
Briefly describe duties of applicant		

AFFIRMATION OF SUPERVISING DENTIST		
I hereby swear or affirm under the penalties of perjury that the information provided herein is true and correct.		
Printed name	Title	
Name of firm or business		
Address of firm or business *(number and street, Rural Route, city, state, ZIP code)*		
Original signature of supervising dentist	Date *(month, day, year)*	Telephone number ( )

APPLICATION AFFIRMATION	
I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.	
Signature of applicant	Date *(month, day, year)*

AUTHORIZATION FOR RELEASE OF INFORMATION
I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for a license to practice dentistry or dental hygiene or for an intern permit. I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information. I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and the Board from any and all liability in connection with such disclosures. A photostatic copy of this authorization has the same force and effect as the orginal.

AFFIRMATION	
I hereby swear or affirm that I have read the above statements and agree to same.	
Signature of applicant	Date *(month, day, year)*